C,L, "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director

March 8, 2007

Lin Dee Hokanson Idaho Falls Recovery Center 1957 East 17th Street Idaho Falls, ID 83404

Dear Mr. Hokanson:

DEBRA RANSOM, R. N., R. H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

This is to advise you of the findings of the Medicare/State Licensure Fire Life Safety survey conducted at Idaho Falls Recovery Center on March 1, 2007.

Enclosed is the Statement of Deficiencies/Plan of Correction, form CMS-2567, and a copy of the State fire safety Statement of Deficiencies/Plan of Correction form listing fire/life safety deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

- 1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for <u>all</u> individuals potentially impacted by the deficient practice.
- 2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
- 3. Identify the date each deficiency has been, or will be, corrected.

After you have answered and dated each deficiency, please sign and date each cover page in the spaces provided. Retain one (1) copy of each page and return the originals to this office by March 21, 2007.

Idaho Falls Recovery Center March 8, 2007 Page 2 of 2

Thank you for the courtesies extended to me during my visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

MARK GRIMES

Supervisor

Facility Fire/Life Safety & Construction Program

MG/mlw

Enclosures

MAR 1 2 2007

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE HOSPITAL			(X3) DATE SURVEY COMPLETED	
130062		130062	B. WING		<u></u> _	03/01/2007	
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE	00,0	1/2007
IDAHO FALLS RECOVERY CENTER					957 EAST 17TH STREET DAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		Κ(000			
	Idaho Falls Recovery Center is a single story story type V (III) facility with a basement, this hospital is licensed for seven (7) beds. The building was constructed in 1992 with plan approval March 1992. The facility is fully sprinkled with a complete smoke detection/fire alarm system; emergency generator; two (2) smoke compartments, and, portable fire extinguishers throughout. Exits include; two exterior, one horizontal, and each patient room has a door directly to the exterior of the building.				RECEI MAR 22 FACILITY STA CEO = LINDER HO	2007 NDARDS	>
	2007, by Mark P. G Safety & Constructi Standards, Idaho D Welfare. The survey was colof the Life Safety C	ey was conducted March 1, rimes, Supervisor, Facility Fire on Section, Bureau of Facility repartment of Health & anducted under the 2000 edition ode, Existing Healthcare			Facilities Manager =	Todd	Page
K 045	NFPA 101 LIFE SA Illumination of mea discharge, is arrang lighting fixture (bulk darkness. (This do	ted March 11, 2003 in 2 CFR 482.41(b). FETY CODE STANDARD ns of egress, including exit ged so that failure of any single b) will not leave the area in es not refer to emergency ce with section 7.8.) 19.2.8	ΚŒ)45	FACILITIES MANAGER WI EMERGENCY Lighting Mo Recorded Results will INTO CEO guarteely	LL Tess withby. be Turn	val
LABORATORY	Based upon observed facility did not ensure the means of egress. This deficient practions are the means of egress.	s not met as evidenced by: ation on March 1, 2007 the re that emergency lighting in s was functional at all times. ce affected all patients and	IATLIRE		Light will be fixed by M		3/24/07 (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ADMINISTRATOR

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	IULTIF	PLE CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED	
AND PLAN OF CORRECTION		DENTRIOATION NONDER.	A. BUI	LDING	02 - ENTIRE HOSPITAL	COMPLE	: I CD
		130062	B. WIN	۷G		03/0	1/2007
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS RECOVERY CENTER				19	EET ADDRESS, CITY, STATE, ZIP CODE 57 EAST 17TH STREET AHO FALLS, ID 83404		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
K 045	Findings include: During the facility to emergency lighting was not operationa indicated that it was operate when teste and acknowledged NFPA 101 LIFE SA A fire alarm system devices or equipme NFPA 72, National effective warning of Activation of the comanual fire alarm ir extinguishing system that manual pull stanurse's stations. Popath of egress. Eletests are available, power is provided, maintained in accorrecords of mainteners.	the survey the census was (7). Our on March 1, 2007 the unit located in the main lobby I. The emergency lighting unit in charge mode, but failed to d. This finding was observed by the Maintenance Engineer. FETY CODE STANDARD with approved components, ent is installed according to Fire Alarm Code, to provide if fire in any part of the building, emplete fire alarm system is by initiation, automatic detection or in operation. Pull stations in eas may be omitted provided attions are within 200 feet of cull stations are located in the extronic or written records of A reliable second source of Fire alarm systems are dance with NFPA 72 and ance are kept readily available, nunciation of the fire alarm			We Change Fire ALAR INSpection Company New Company did A Device Test 3-12-0 Put us on their Annu inspection List. Facility MANAGER WILL MAKE S WE ARE IN COMPLIENCE	in.	3/12/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE HOSPITAL			COMPLETED	
		130062	B. WING			03/01/2007	
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS RECOVERY CENTER				19	EET ADDRESS, CITY, STATE, ZIP CODE 957 EAST 17TH STREET DAHO FALLS, ID 83404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 051	Continued From pa	ge 2	ΚŒ)51			
	Based upon record ensure proper mair the building fire ala practice affected al	s not met as evidenced by: review, the facility failed to ntenance and annual testing of rm system. This deficient I patients and staff, on the day ensus was reported as seven					
K 064	facility had not mair alarm system durin latest record of a fir 8/23/04. NFPA 101 LIFE SA Portable fire extings	w it was determined that the ntained and tested the fire g the last 12 months. The re alarm test was dated FETY CODE STANDARD uishers are provided in all ncies in accordance with NFPA 10	Κ€)64	FACILITIES MANAGER U FIRE EN EXTINGUISHERS I MONTHLY & TURN INSPECTION OF CEG GUARTERLY	vill do Napection Tion Re,	us popets
	Based upon observensure compliance checks of all fire ex This deficient pract staff, on the day of reported as seven (Findings include: During the facility to determined that not	s not met as evidenced by: ration the facility failed to by not completing monthly tinguishers within the building. ice affected all patients and the survey the census was (7). our on March 1, 2007 it was all fire extinguishers had not a monthly basis and tags			Deficiency correcte		i i

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A. BUILDING 02 - ENTIRE HOSPITAL		
130062 B. WING	03/01/2007	
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS RECOVERY CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1957 EAST 17TH STREET IDAHO FALLS, ID 83404		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION) TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	(X5) COMPLETION DATE	
K 084 Continued From page 3 initialed throughout the facility. This deficient practice affected all patients and staff, on the day of the survey the census was reported as seven (7). This deficient practice was observed and acknowledged by the Maintenance Engineer.		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 02 - ENTIRE HOSPITAL B. WING 130062 03/01/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1957 EAST 17TH STREET **IDAHO FALLS RECOVERY CENTER** IDAHO FALLS, ID 83404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) B 000 16.03.14 Initial Comments B 000 Refer to Fed K Tag S For Compliance

Per phoner call with:

Administrator

Lin Dar Hokan Son, Administrator

3/26/07

MP4 Idaho Falls Recovery Center is a single story story type V (III) facility with a basement, this hospital is licensed for seven (7) beds. The building was constructed in 1992 with plan approval March 1992. The facility is fully sprinkled with a complete smoke detection/fire alarm system; emergency generator; two (2) smoke compartments, and, portable fire extinguishers throughout. Exits include: two exterior, one horizontal, and each patient room has a door directly to the exterior of the building. The fire safety survey was conducted March 1, 2007, by Mark P. Grimes, Supervisor, Facility Fire Safety & Construction Section, Bureau of Facility Standards, Idaho Department of Health & Welfare. The following deficiencies were cited in accordance with IDAPA 16.03.14 BB505 16.03.14.510.07 Maintenance of Equipment BB505 07. Maintenance of Equipment. The hospital shall establish routine test, check, and maintenance procedures for alarm systems, extinguishment systems, and all essential electrical systems. Frequency of testing, checks, and maintenance shall be in accordance with applicable National RECEIVED Fire Protection Association Standards referenced in Appendix B of the 1985 "Life Safety Code" or MAR 2 2 2007 as adopted by the Idaho State Fire Marshal. (10-14-88)FACILITY STANDARDS This Rule is not met as evidenced by: Refer to deficiencies cited under Tags K045. K051 and K064 on the federal form CMS 2567 Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

JS0C21

TITLE

If continuation sheet 1 of 1

(X6) DATE